SkyConnect
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ASSEMBLE INSURANCE TANZANIA LTD

Software Requirements Specification

SAS Claims & Case Management Module

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https://www.assemble.co.tz/

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1 Document Information

Field	Value
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Platforms	['Web', 'Mobile']
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Module Code	CLAIMS
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2 Project Overview

2.1 What Are We Building

2.1.1 System Function

Comprehensive claims processing and case management system for health insurance operations, supporting end-to-end claims lifecycle from member verification through adjudication to payment processing

2.1.2 Users

- Claims Processors (internal staff)
- Claims Managers (approval workflows)
- Provider Staff (claims submission, member verification)
- Members (claims status tracking)
- Finance Officers (payment processing)
- Case Managers (complex case handling)
- Medical Reviewers (clinical review)

2.1.3 Problem Solved

Manual claims processing taking 5-7 days, lack of real-time member verification, no biometric authentication, limited provider integration, manual reconciliation processes, and no automated adjudication rules

2.1.4 Key Success Metric

Claims processing time reduced from 5-7 days to <24 hours for standard claims, <1 hour for auto-adjudicated claims, 95% auto-adjudication rate for simple claims, <2 seconds member verification response time

2.2 Scope

2.2.1 In Scope

- Multi-modal member verification (fingerprint, facial recognition, OTP, offline mode)

- Real-time eligibility checking with benefit limits and waiting periods
- Online pre-authorization workflow for services requiring approval
- Electronic claims submission via provider portal and API
- Auto-adjudication engine with configurable rules
- Manual claims vetting and approval workflows
- Multiple settlement channels (policy benefits, indemnity, excess of loss, ex-gratia, SBP/Buffer)
- Claims reconciliation and provider invoice management
- ICD-10 diagnosis code management
- Claims reporting and analytics
- Integration with provider systems for electronic claims
- SMS/email notifications for claim status updates
- Maker-checker approval workflows
- Claims reversal and correction functionality
- Exception handling and fraud detection alerts

2.2.2 Out Of Scope

- Third-party administrator (TPA) integration (future phase)
- AI-based fraud detection (basic rules only in Phase 1)
- Telemedicine claims processing
- International claims processing
- Direct billing to reinsurers

3 User Requirements

3.1 Member Verification

Feature Code	I Want To	So That I Can	Priority	Notes
FT-CLAIMS-VERIFY-FINGER	Verify member identity using fingerprint biometric scanning	Confirm member eligibility and prevent fraud before providing medical services	Must	Requires USB fingerprint scanner. Response time <2 seconds. Offline mode with sync support.
FT-CLAIMS-VERIFY-FACE	Verify member identity using facial recognition	Provide biometric verification when fingerprint is not available	Should	Webcam or mobile camera required. AI-based face matching. Liveness detection to prevent photo spoofing.
FT-CLAIMS-VERIFY-OTP	Verify member identity using SMS/Email OTP	Provide verification when biometric devices are unavailable	Must	OTP valid for 5 minutes. Maximum 3 retry attempts. SMS and email delivery.
FT-CLAIMS-VERIFY-OFFLINE	Verify members when internet connectivity is unavailable	Continue service delivery during network outages	Must	Local cache of active members. Sync verification logs when online. Maximum 24-hour offline operation.

Feature Code	I Want To	So That I Can	Priority	Notes
FT-CLAIMS-VERIFY-EXCEPTION	Handle verification exceptions with approval workflow	Provide services when standard verification fails but member identity is confirmed through other means	Should	Manager approval required. Audit trail logging. Maximum exception validity: same day only.

3.2 Pre Authorization

Feature Code	I Want To	So That I Can	Priority	Notes
FT-CLAIMS-PRE-AUTH-REQUEST	Submit pre-authorization requests online for services requiring approval	Get approval before providing expensive or specialized medical services	Must	Services requiring pre-auth: hospitalization, maternity, dental, optical, chronic medication. Attach supporting documents.
FT-CLAIMS-PRE-AUTH-APPROVE	Review and approve/reject pre-authorization requests	Control costs and ensure medical necessity	Must	SLA: 24 hours for routine, 4 hours for emergency. Approval with conditions/ limits. Rejection with reasons.
FT-CLAIMS-PRE-AUTH-TRACK	Track pre-authorization request status in real-time	Know when approval is granted and proceed with service delivery	Should	Status: Pending, Under Review, Approved, Rejected, Expired. SMS/ email

Feature Code	I Want To	So That I Can	Priority	Notes
				notifications on status change.
FT-CLAIMS-PRE-AUTH-REVERSE	Reverse or cancel approved pre-authorizations	Handle cancelled procedures or erroneous approvals	Should	Reversal only before claim submission. Manager approval required. Audit trail maintained.

3.3 Claims Submission

Feature Code	I Want To	So That I Can	Priority	Notes
FT-CLAIMS-SUBMIT-PROVIDER	Submit claims electronically via provider portal	Process claims faster without manual paper submission	Must	Link to member verification record. Attach scanned documents. Real-time validation of required fields.
FT-CLAIMS-SUBMIT-INVOICE-ACK	Generate provider invoice acknowledgement with claim count and total	Confirm receipt of claims batch from provider	Must	Details: Invoice number, amount, provider name, claim count, date received. Auto-generated reference number.
FT-CLAIMS-REGISTER-MANUAL	Register claims manually from paper submissions	Process claims from providers without portal access	Must	Scan and attach claim forms. Link to member. Capture all service items. Classify as IP/OP.

Feature Code	I Want To	So That I Can	Priority	Notes
FT-CLAIMS-CLASSIFY-IPOP	Automatically classify claims as Inpatient or Outpatient	Apply correct policy clauses and benefit limits	Must	Based on service type mapping. Affects benefit utilization tracking and limits.
FT-CLAIMS-DIAGNOSIS-ICD10	Capture and validate ICD-10 diagnosis codes	Ensure accurate medical coding and analytics	Must	Complete ICD-10 code library. Support for multiple diagnoses. Primary diagnosis flagging. Code search functionality.
FT-CLAIMS-ITEMS-TARIFF	Map provider service items to internal tariff codes	Apply standardized pricing and benefit coverage rules	Must	Provider item to internal tariff mapping. Display both provider and internal names during vetting.
FT-CLAIMS-ATTACH-DOCS	Upload and attach claim supporting documents	Provide medical justification for services rendered	Must	Supported formats: PDF, JPG, PNG. Maximum 10MB per file. Multiple files per claim. Document types: lab results, prescriptions, referral letters, discharge summaries.

3.4 Claims Adjudication

Feature Code	I Want To	So That I Can	Priority	Notes
FT-CLAIMS-AUTO-ADJUDICATE	Automatically adjudicate claims against policy rules	Process simple claims instantly without manual review	Must	Rules: benefit limits, waiting periods, exclusions, annual limits, gender-specific benefits, age restrictions. Auto-approve if all rules pass.
FT-CLAIMS-VET-MANUAL	Manually vet and review claims requiring human judgment	Make informed decisions on complex or high-value claims	Must	Display: member demographics, policy details, benefit limits, utilization history, special notes. Approve, reject, or query functionality.
FT-CLAIMS-REJECT-REASONS	Reject claims with coded rejection reasons	Provide clear feedback to providers on why claims were denied	Must	Standard rejection codes: benefit exhausted, waiting period, service not covered, pre-auth missing, duplicate claim, member inactive. Free text notes field.
FT-CLAIMS-PARTIAL-APPROVE	Partially approve claims when some items are inadmissible	Pay for covered services while rejecting non-covered items	Must	Item-level adjudication. Admissible amount processed through original

Feature Code	I Want To	So That I Can	Priority	Notes
				benefit. Rejected items flagged with reasons.
FT-CLAIMS-WAITING-PERIOD	Enforce waiting period restrictions during adjudication	Prevent claims for services still under waiting period	Must	Waiting periods configured per benefit and per member entry date. Display remaining days. Auto-reject claims during waiting period.
FT-CLAIMS-BENEFIT-LIMITS	Check and enforce benefit limits (per visit, annual, lifetime)	Control utilization according to policy terms	Must	Limits: per visit, per day, per year, lifetime. Track utilization across claims. Display remaining balance. Auto-reject when limit exceeded.
FT-CLAIMS-GENDER-VALIDATE	Validate gender-specific services against member gender	Prevent claims for biologically inappropriate services	Must	Examples: maternity for males, prostate services for females. Auto-reject with clear reason. Override with manager approval.
FT-CLAIMS-AGE-VALIDATE	Validate age-appropriate services against member age	Flag unusual claims requiring review	Should	Age ranges per service type. Flag for review (not auto-reject). Examples: pediatric services for adults, geriatric for children.

3.5 Alternative Settlement

Feature Code	I Want To	So That I Can	Priority	Notes
FT-CLAIMS-SBP-PROCESS	Process rejected claims through Special Benefit Pool (SBP)	Provide coverage when benefit limits are exceeded	Must	SBP configured per policy or benefit. Check SBP fund availability. Deduct from SBP balance. Requires approval workflow.
FT-CLAIMS-BUFFER-PROCESS	Process excess claims through Buffer/Excess of Loss cover	Handle high-cost claims exceeding policy limits	Must	Buffer configured per benefit or policy-wide. Automatic if buffer available. Track buffer utilization. Report to reinsurance.
FT-CLAIMS-INDEMNITY-PROCESS	Process claims through indemnity channel	Settle claims not covered by insurance but reimbursable by client	Must	Client approval required. Generate invoice to client for indemnity claims. Track indemnity utilization. Multiple approval levels.
FT-CLAIMS-EXGRATIA-PROCESS	Process claims through ex-gratia (goodwill) channel	Settle exceptional cases for customer satisfaction	Must	Management approval required. Document business justification. Track ex-gratia spending. Limit

Feature Code	I Want To	So That I Can	Priority	Notes
				per policy period.
FT-CLAIMS-MULTI-CHANNEL	Process single claim through multiple settlement channels	Maximize coverage using all available options	Should	Sequence: Policy benefit → SBP/ Buffer → Indemnity → Ex-gratia. Track amounts per channel. Approval per channel rules.

3.6 Claims Payment

Feature Code	I Want To	So That I Can	Priority	Notes
FT-CLAIMS-PAYMENT-VOUCHER	Generate payment vouchers for approved claims	Authorize payment to providers	Must	Batch multiple claims per provider. Include claim details, amounts, deductions. Integration with Sage ERP for AP.
FT-CLAIMS-TRANSMITTAL	Generate claims transmittal report showing claimed vs payable amounts	Communicate adjudication results to providers	Must	Summary and detailed views. Show total claimed, total payable, rejected amounts with reasons. Export to PDF/Excel.
FT-CLAIMS-NOTIFY-MEMBER	Send SMS notification to member on claim utilization	Keep member informed of benefit usage	Should	Message includes: service date, provider, amount utilized, remaining balance. Sent

Feature Code	I Want To	So That I Can	Priority	Notes
				after claim approval.
FT-CLAIMS-PROVIDER-STATEMENT	Generate provider statement showing all transactions	Provide comprehensive account status to providers	Must	Include: claims submitted, approved, rejected, paid, pending. Running balance. As-at-date functionality.

3.7 Claims Reconciliation

Feature Code	I Want To	So That I Can	Priority	Notes
FT-CLAIMS-RECONCILE-PROVIDER	Reconcile provider invoices against processed claims	Ensure accurate payment and identify discrepancies	Must	Match invoice to claims. Flag discrepancies (missing claims, amount differences). Adjustment workflow. Link to payment voucher.
FT-CLAIMS-REVERSE-CLAIM	Reverse claims and payment vouchers with proper controls	Correct errors and handle duplicate submissions	Must	Controls: Check if already paid, require approval, document reason. Credit member balance. Create reversal audit trail. Alert if payment made.
	Detect and prevent		Must	Check: member + provider +

Feature Code	I Want To	So That I Can	Priority	Notes
FT-CLAIMS-DUPLICATE-CHECK	duplicate claim submissions	Avoid paying twice for the same service		service date + service type. Flag for review. Allow override with justification.
FT-CLAIMS-TERMINATED-PROCESS	Process claims for members terminated after service date	Honor valid claims within grace period	Must	Grace period: up to last service date if member was active. Auto-reject if terminated before service. Warning message during vetting.

3.8 Claims Reporting

Feature Code	I Want To	So That I Can	Priority	Notes
FT-CLAIMS-REGISTER-REPORT	Generate claims register report with comprehensive details	Track all claims and their status	Must	Filters: date range, provider, member, status, claim type. Export to Excel. Include all claim fields.
FT-CLAIMS-STATUS-REPORT	View claims status dashboard showing pipeline	Monitor claims processing workflow	Must	Stages: Submitted, Vetting, Approved, Rejected, Paid. Count and total value per stage. Aging analysis.
FT-CLAIMS-UTILIZATION-MEMBER	Generate member/family	Track benefit usage per member	Must	Show: total claims, approved

Feature Code	I Want To	So That I Can	Priority	Notes
	utilization report			amounts, remaining limits. By benefit type. Comparison to premium paid (claim ratio).
FT-CLAIMS-UTILIZATION-CORPORATE	Generate corporate utilization report with claim ratio	Analyze group performance for renewals	Must	Metrics: total claims, claim ratio, average claim cost (IP/OP), high claimants, benefit utilization. Trend analysis.
FT-CLAIMS-EXCEPTION-REPORT	Generate exception reports flagging unusual patterns	Detect potential fraud and abuse	Must	Alerts: high claim amounts, frequent visits, unusual diagnoses, after-hours claims, excessive repeat procedures. Configurable thresholds.
FT-CLAIMS-PROVIDER-PERFORMANCE	Analyze claims experience per provider	Identify high-cost providers and network optimization opportunities	Should	Metrics: total claims, average cost, rejection rate, turnaround time. Provider ranking. Cost comparison.
FT-CLAIMS-AGE-REGION-ANALYSIS	Analyze claim experience by age band and region	Support actuarial pricing and risk assessment	Should	Segmentation: age bands (0-18, 19-35, 36-50, 51-65, 65+), regions, gender. Claim frequency and severity.

Feature Code	I Want To	So That I Can	Priority	Notes
FT-CLAIMS-EXCEEDED-BENEFITS	Generate report on exceeded benefits requiring alternative settlement	Track usage of SBP, Buffer, Indemnity, Ex-gratia	Must	Per client, member, benefit type. Total amounts per channel. Approval tracking.

4 Detailed Feature Requirements

4.1 Ft Claims Verify Finger

4.1.1 Priority

Must Have

4.1.2 User Story

As a provider staff member, I want to verify member identity using fingerprint biometric scanning so that I can confirm they are eligible for services and prevent fraud before providing medical care

4.1.3 Preconditions

USB fingerprint scanner connected and configured, member has enrolled fingerprint on file, internet connectivity available or offline sync configured, provider logged into provider portal

4.1.4 Postconditions

Member identity verified successfully, verification record created with timestamp and location, member eligibility status displayed with benefit details, verification linked to upcoming claim submission

4.1.5 Test Cases

Id	Description	Weight
VERIFY-FINGER-TC-001	Verify successful fingerprint verification for member with enrolled fingerprint returns member details within 2 seconds	High
VERIFY-FINGER-TC-002	Verify system displays appropriate error message when fingerprint does not match any enrolled member	High
VERIFY-FINGER-TC-003		High

Id	Description	Weight
	Verify system displays member eligibility status (active/inactive/suspended) immediately after successful verification	
VERIFY-FINGER-TC-004	Verify system displays remaining benefit limits for all benefit categories after verification	High
VERIFY-FINGER-TC-005	Verify verification record is logged with timestamp, provider location, and staff member ID	Medium
VERIFY-FINGER-TC-006	Verify system works offline and syncs verification records when connection restored	High
VERIFY-FINGER-TC-007	Verify system handles poor quality fingerprint scans with retry prompts (max 3 attempts)	Medium
VERIFY-FINGER-TC-008	Verify system displays waiting period restrictions and exclusions after successful verification	High

4.2 Ft Claims Verify Face

4.2.1 Priority

Should Have

4.2.2 User Story

As a provider staff member, I want to verify member identity using facial recognition so that I can provide biometric verification when fingerprint scanner is not available or fingerprint quality is poor

4.2.3 Preconditions

Webcam or mobile camera available and accessible, member has enrolled facial photo on file, facial recognition AI model loaded, adequate lighting conditions, provider logged in

4.2.4 Postconditions

Member identity verified via facial recognition, verification record created with photo capture timestamp, member eligibility displayed, liveness check passed to prevent photo spoofing

4.2.5 Test Cases

Id	Description	Weight
VERIFY-FACE-TC-001	Verify successful facial recognition verification returns member details within 3 seconds	High
VERIFY-FACE-TC-002	Verify liveness detection prevents verification using printed photos or displayed images	High
VERIFY-FACE-TC-003	Verify system prompts user to adjust position/lighting when face detection quality is poor	Medium
VERIFY-FACE-TC-004	Verify verification fails gracefully when no face detected in camera frame	Medium
VERIFY-FACE-TC-005	Verify system captures and stores verification photo as audit trail	High
VERIFY-FACE-TC-006	Verify facial recognition works with reasonable variations (glasses, beard growth, aging)	High
VERIFY-FACE-TC-007	Verify system displays confidence score and allows manual override if score is marginal (60-80%)	Medium

4.3 Ft Claims Verify Otp

4.3.1 Priority

Must Have

4.3.2 User Story

As a provider staff member, I want to verify member identity using SMS/Email OTP so that I can confirm member eligibility when biometric devices are unavailable or offline

4.3.3 Preconditions

Member has registered phone number and/or email on file, SMS gateway and email service operational, member has access to phone/email, provider portal open

4.3.4 Postconditions

OTP sent to member contact, member provides OTP code to provider staff, OTP validated successfully, member identity verified, verification record created

4.3.5 Test Cases

Id	Description	Weight
VERIFY-OTP-TC-001	Verify OTP sent via SMS to registered phone number within 30 seconds	High
VERIFY-OTP-TC-002	Verify OTP sent via email to registered email address within 1 minute	High
VERIFY-OTP-TC-003	Verify correct OTP entry successfully verifies member identity	High
VERIFY-OTP-TC-004	Verify incorrect OTP displays error message and allows retry (max 3 attempts)	High
VERIFY-OTP-TC-005		High

Id	Description	Weight
	Verify OTP expires after 5 minutes and new OTP must be requested	
VERIFY-OTP-TC-006	Verify member is locked out for 15 minutes after 3 failed OTP attempts	Medium
VERIFY-OTP-TC-007	Verify provider can resend OTP if member did not receive initial message	Medium
VERIFY-OTP-TC-008	Verify OTP format is 6-digit numeric code for SMS and alphanumeric for email	Low

4.4 Ft Claims Verify Offline

4.4.1 Priority

Must Have

4.4.2 User Story

As a provider staff member in a facility with unreliable internet, I want to verify members offline using locally cached data so that I can continue service delivery during network outages without disruption

4.4.3 Preconditions

Provider has enabled offline mode, active member database synchronized to local device within last 24 hours, fingerprint scanner connected locally, verification app installed

4.4.4 Postconditions

Member verified using local database, verification record queued for sync, member eligibility checked against cached policy data, verification logs uploaded when online

4.4.5 Test Cases

Id	Description	Weight
VERIFY-OFFLINE-TC-001	Verify fingerprint verification works using locally cached member database when offline	High
VERIFY-OFFLINE-TC-002	Verify offline verification displays last sync timestamp to inform staff of data freshness	High
VERIFY-OFFLINE-TC-003	Verify verification records are queued and automatically synced when connection restored	High
VERIFY-OFFLINE-TC-004	Verify system displays warning when local database is older than 24 hours	High
VERIFY-OFFLINE-TC-005	Verify offline mode prevents verification if local database is older than 48 hours	High
VERIFY-OFFLINE-TC-006	Verify sync conflict resolution when member status changed on server during offline period	Medium
VERIFY-OFFLINE-TC-007	Verify multiple verification records batch sync efficiently without duplicates	Medium

4.5 Ft Claims Verify Exception

4.5.1 Priority

Should Have

4.5.2 User Story

As a provider manager, I want to approve verification exceptions so that I can provide services when standard verification fails but member identity is confirmed through alternative means (ID card, etc.)

4.5.3 Preconditions

Standard verification methods failed or unavailable, provider staff has confirmed member identity through manual document check, manager is available for approval, provider portal with manager access

4.5.4 Postconditions

Exception approval granted with reason documented, temporary verification valid for current visit only, audit trail created with approver details, exception flagged for review

4.5.5 Test Cases

Id	Description	Weight
VERIFY-EXCEPTION-TC-001	Verify staff can request verification exception with mandatory reason field	High
VERIFY-EXCEPTION-TC-002	Verify manager receives real-time notification of exception request	High
VERIFY-EXCEPTION-TC-003	Verify manager can approve or reject exception with comments	High
VERIFY-EXCEPTION-TC-004	Verify approved exception creates verification record valid for same day only	High
VERIFY-EXCEPTION-TC-005	Verify exception approval requires photo of member ID or alternative identification document	High
VERIFY-EXCEPTION-TC-006	Verify all exception verifications are flagged in audit reports for review	Medium
VERIFY-EXCEPTION-TC-007	Verify excessive exceptions by provider or member trigger fraud alert	Medium

4.6 Ft Claims Pre Auth Request

4.6.1 Priority

Must Have

4.6.2 User Story

As a provider staff member, I want to submit pre-authorization requests online for services requiring approval so that I can get approval before providing expensive medical services and ensure payment

4.6.3 Preconditions

Member verified and active, service requires pre-authorization per policy rules, provider portal access, supporting medical documents available, member consent obtained

4.6.4 Postconditions

Pre-authorization request submitted with unique reference number, request routed to appropriate approver, SMS/email notification sent to member and provider, request visible in tracking system

4.6.5 Test Cases

Id	Description	Weight
PRE-AUTH-REQ-TC-001	Verify pre-auth request form captures all mandatory fields (member, service, estimated cost, diagnosis, medical justification)	High
PRE-AUTH-REQ-TC-002	Verify supporting documents can be attached (doctor's letter, lab results, X-rays) up to 10MB per file	High
PRE-AUTH-REQ-TC-003	Verify request automatically routes to medical reviewer for services requiring clinical review	High
PRE-AUTH-REQ-TC-004	Verify unique pre-authorization reference	High

Id	Description	Weight
	number generated and displayed immediately	
PRE-AUTH-REQ-TC-005	Verify SMS notification sent to member with pre-auth reference number	Medium
PRE-AUTH-REQ-TC-006	Verify system displays member's remaining benefit limits for requested service	High
PRE-AUTH-REQ-TC-007	Verify emergency pre-auth requests are flagged and routed with priority SLA (4 hours)	High
PRE-AUTH-REQ-TC-008	Verify request displays member's claim history for same diagnosis/service	Medium

4.7 Ft Claims Pre Auth Approve

4.7.1 Priority

Must Have

4.7.2 User Story

As a claims manager or medical reviewer, I want to review and approve/reject pre-authorization requests so that I can control costs and ensure medical necessity before expensive services are provided

4.7.3 Preconditions

Pre-authorization request submitted and assigned to reviewer, reviewer has appropriate permissions, medical records attached to request, policy details accessible

4.7.4 Postconditions

Pre-authorization approved or rejected with clear reasons, approval includes any conditions or limits, provider and member notified, approved amount reserved against benefit limit

4.7.5 Test Cases

Id	Description	Weight
PRE-AUTH-APPROVE-TC-001	Verify reviewer can access all pre-auth requests assigned to them in dashboard	High
PRE-AUTH-APPROVE-TC-002	Verify request displays complete member information, policy details, benefit limits, and utilization history	High
PRE-AUTH-APPROVE-TC-003	Verify reviewer can approve request with specific approved amount (which may differ from requested amount)	High
PRE-AUTH-APPROVE-TC-004	Verify approval can include conditions (e.g., specific doctor, specific facility, specific procedure)	High
PRE-AUTH-APPROVE-TC-005	Verify rejection requires selection of rejection reason from standard codes plus free text notes	High
PRE-AUTH-APPROVE-TC-006	Verify approval/rejection triggers immediate SMS and email notification to provider and member	High
PRE-AUTH-APPROVE-TC-007	Verify routine pre-auth requests exceeding 24-hour SLA are escalated and highlighted	Medium
PRE-AUTH-APPROVE-TC-008	Verify emergency pre-auth requests exceeding 4-hour SLA trigger alerts to management	High
PRE-AUTH-APPROVE-TC-009	Verify approved amount is reserved against member's	High

Id	Description	Weight
	benefit limit and shown in real-time balance	

4.8 Ft Claims Pre Auth Track

4.8.1 Priority

Should Have

4.8.2 User Story

As a provider staff member or member, I want to track pre-authorization request status in real-time so that I know when approval is granted and can proceed with service delivery

4.8.3 Preconditions

Pre-authorization request submitted, tracking reference number available, internet connectivity available, portal or mobile app access

4.8.4 Postconditions

Current pre-authorization status displayed, status history timeline shown, notifications configured for status changes, estimated approval time displayed

4.8.5 Test Cases

Id	Description	Weight
PRE-AUTH-TRACK-TC-001	Verify pre-auth tracking page displays current status (Pending, Under Review, Approved, Rejected, Expired)	High
PRE-AUTH-TRACK-TC-002	Verify status timeline shows all status changes with timestamps and reviewer names	Medium
PRE-AUTH-TRACK-TC-003		High

Id	Description	Weight
	Verify SMS notification sent when status changes to Approved or Rejected	
PRE-AUTH-TRACK-TC-004	Verify approved pre-auth displays approved amount, conditions, and validity period	High
PRE-AUTH-TRACK-TC-005	Verify rejected pre-auth displays rejection reasons and suggests next steps	High
PRE-AUTH-TRACK-TC-006	Verify pre-auth automatically expires after validity period (e.g., 30 days) and shows expired status	Medium
PRE-AUTH-TRACK-TC-007	Verify provider and member can access tracking using reference number without login	Medium

4.9 Ft Claims Pre Auth Reverse

4.9.1 Priority

Should Have

4.9.2 User Story

As a claims manager, I want to reverse or cancel approved pre-authorizations so that I can handle cancelled procedures or correct erroneous approvals

4.9.3 Preconditions

Pre-authorization previously approved, no claim submitted against the pre-auth yet, manager has reversal permissions, reason for reversal documented

4.9.4 Postconditions

Pre-authorization marked as reversed/cancelled, reserved benefit amount released back to member limit, provider and member notified, audit trail created with reversal reason

4.9.5 Test Cases

Id	Description	Weight
PRE-AUTH-REVERSE-TC-001	Verify manager can reverse pre-authorization that has not been used for claim submission	High
PRE-AUTH-REVERSE-TC-002	Verify reversal requires mandatory reason selection and free text justification	High
PRE-AUTH-REVERSE-TC-003	Verify system prevents reversal if claim already submitted against the pre-auth	High
PRE-AUTH-REVERSE-TC-004	Verify reserved benefit amount is immediately released back to member's available limit	High
PRE-AUTH-REVERSE-TC-005	Verify SMS and email notification sent to provider and member about reversal	Medium
PRE-AUTH-REVERSE-TC-006	Verify reversal audit trail includes timestamp, manager name, reason, and original approval details	High
PRE-AUTH-REVERSE-TC-007	Verify pre-auth status changes to 'Reversed' and original details remain visible for audit	Medium

4.10 Ft Claims Submit Provider

4.10.1 Priority

Must Have

4.10.2 User Story

As a provider staff member, I want to submit claims electronically via provider portal so that I can process claims faster without manual paper submission and reduce processing time

4.10.3 Preconditions

Member verified using biometric/OTP, services rendered and documented, provider logged into portal, service items mapped to tariff codes, required documents scanned

4.10.4 Postconditions

Claim submitted successfully with unique claim number, validation checks passed, claim visible in provider's submitted claims list, confirmation email sent to provider

4.10.5 Test Cases

Id	Description	Weight
SUBMIT-PROVIDER-TC-001	Verify claim submission form pre-populates with member details from recent verification	High
SUBMIT-PROVIDER-TC-002	Verify real-time validation of mandatory fields (service date, diagnosis, service items, amounts)	High
SUBMIT-PROVIDER-TC-003	Verify service items can be added with quantity, unit price, and total calculated automatically	High
SUBMIT-PROVIDER-TC-004	Verify ICD-10 diagnosis code search and selection with code descriptions	High
SUBMIT-PROVIDER-TC-005	Verify supporting documents (prescription, lab results) can be attached up to 10MB each	High
SUBMIT-PROVIDER-TC-006	Verify claim automatically linked to pre-authorization if reference number provided	High

Id	Description	Weight
SUBMIT-PROVIDER-TC-007	Verify unique claim number generated and displayed immediately upon successful submission	High
SUBMIT-PROVIDER-TC-008	Verify submission confirmation email sent to provider with claim details and tracking number	Medium
SUBMIT-PROVIDER-TC-009	Verify service date cannot be in the future or more than 90 days in the past	High

4.11 Ft Claims Submit Invoice Ack

4.11.1 Priority

Must Have

4.11.2 User Story

As a provider, I want to receive an invoice acknowledgement with claim count and total amount so that I have confirmation of claims batch received by the insurance company

4.11.3 Preconditions

Provider has submitted multiple claims (batch), all claims passed initial validation, claims grouped by invoice/submission batch, provider portal session active

4.11.4 Postconditions

Invoice acknowledgement generated with unique reference, displays invoice number, total claims count, total claimed amount, provider name, date received, PDF available for download

4.11.5 Test Cases

Id	Description	Weight
INVOICE-ACK-TC-001		High

Id	Description	Weight
	Verify invoice acknowledgement auto-generated after batch submission with unique reference number	
INVOICE-ACK-TC-002	Verify acknowledgement displays invoice number, provider name, submission date, and received date	High
INVOICE-ACK-TC-003	Verify acknowledgement shows total number of claims in batch	High
INVOICE-ACK-TC-004	Verify acknowledgement shows total claimed amount summed across all claims	High
INVOICE-ACK-TC-005	Verify acknowledgement available for download as PDF from provider portal	High
INVOICE-ACK-TC-006	Verify acknowledgement email sent automatically to provider's registered email	Medium
INVOICE-ACK-TC-007	Verify provider can access historical acknowledgements from portal	Medium

4.12 Ft Claims Register Manual

4.12.1 Priority

Must Have

4.12.2 User Story

As a claims processor, I want to register claims manually from paper submissions so that I can process claims from providers without portal access or electronic submission capability

4.12.3 Preconditions

Paper claim forms received from provider, forms scanned and uploaded to document management system, claims processor logged into admin portal, member details verified

4.12.4 Postconditions

Claim registered in system with all details captured, scanned documents attached to claim record, claim classified as IP/OP, claim enters adjudication queue

4.12.5 Test Cases

Id	Description	Weight
REGISTER-MANUAL-TC-001	Verify claims processor can search and select member using membership number, ID number, or name	High
REGISTER-MANUAL-TC-002	Verify manual claim entry form captures all fields present on paper form	High
REGISTER-MANUAL-TC-003	Verify multiple service items can be added with individual amounts	High
REGISTER-MANUAL-TC-004	Verify scanned claim documents can be attached and linked to claim record	High
REGISTER-MANUAL-TC-005	Verify claim automatically classified as Inpatient or Outpatient based on service type	High
REGISTER-MANUAL-TC-006	Verify duplicate check runs against existing claims (member + provider + service date)	High
REGISTER-MANUAL-TC-007	Verify manually registered claim generates unique claim number and enters vetting queue	High

Id	Description	Weight
REGISTER-MANUAL-TC-008	Verify claims processor identity logged for audit trail of manual registrations	Medium

4.13 Ft Claims Classify Ipop

4.13.1 Priority

Must Have

4.13.2 User Story

As the system, I want to automatically classify claims as Inpatient or Outpatient so that correct policy clauses and benefit limits are applied during adjudication

4.13.3 Preconditions

Claim submitted or registered, service types configured with IP/OP classification, tariff codes mapped to service categories

4.13.4 Postconditions

Claim classified as Inpatient or Outpatient, classification visible on claim record, correct benefit limits applied based on classification, separate utilization tracking

4.13.5 Test Cases

Id	Description	Weight
CLASSIFY-IPOP-TC-001	Verify claims with admission/ discharge dates automatically classified as Inpatient	High
CLASSIFY-IPOP-TC-002	Verify claims without admission dates classified as Outpatient	High
CLASSIFY-IPOP-TC-003	Verify emergency room visits without admission classified as Outpatient	Medium

Id	Description	Weight
CLASSIFY-IPOP-TC-004	Verify day surgery procedures classified based on configured rules (IP or OP per policy)	High
CLASSIFY-IPOP-TC-005	Verify classification displayed prominently on claim vetting screen	Medium
CLASSIFY-IPOP-TC-006	Verify IP and OP benefit limits applied separately based on classification	High
CLASSIFY-IPOP-TC-007	Verify claims processor can manually override classification with justification	Medium

4.14 Ft Claims Diagnosis Icd10

4.14.1 Priority

Must Have

4.14.2 User Story

As a provider or claims processor, I want to capture and validate ICD-10 diagnosis codes so that claims have accurate medical coding for adjudication and analytics

4.14.3 Preconditions

Complete ICD-10 code library loaded in system, claim submission or registration form open, provider or processor has basic ICD-10 knowledge

4.14.4 Postconditions

Primary diagnosis captured with valid ICD-10 code, secondary diagnoses captured if applicable, diagnosis descriptions displayed, codes validated against ICD-10 library

4.14.5 Test Cases

Id	Description	Weight
DIAGNOSIS-ICD10-TC-001	Verify ICD-10 code search functionality returns matching codes based on keyword search	High
DIAGNOSIS-ICD10-TC-002	Verify code selection displays full diagnosis description and code	High
DIAGNOSIS-ICD10-TC-003	Verify system supports multiple diagnosis codes per claim with primary diagnosis flagged	High
DIAGNOSIS-ICD10-TC-004	Verify invalid or non-existent ICD-10 codes rejected with clear error message	High
DIAGNOSIS-ICD10-TC-005	Verify diagnosis code required as mandatory field before claim submission	High
DIAGNOSIS-ICD10-TC-006	Verify recently used diagnosis codes displayed for quick selection	Medium
DIAGNOSIS-ICD10-TC-007	Verify ICD-10 code browse functionality by category and chapter	Medium

4.15 Ft Claims Items Tariff

4.15.1 Priority

Must Have

4.15.2 User Story

As the system, I want to map provider service items to internal tariff codes so that standardized pricing and benefit coverage rules can be applied consistently

4.15.3 Preconditions

Provider's fee schedule loaded in system, internal tariff library configured, tariff-to-benefit mapping established, claim with service items entered

4.15.4 Postconditions

Provider service items mapped to internal tariff codes, both provider and internal descriptions displayed, tariff pricing applied, benefit eligibility checked per tariff code

4.15.5 Test Cases

Id	Description	Weight
ITEMS-TARIFF-TC-001	Verify provider service items automatically mapped to internal tariff codes based on configuration	High
ITEMS-TARIFF-TC-002	Verify vetting screen displays both provider item name and internal tariff description	High
ITEMS-TARIFF-TC-003	Verify tariff pricing applied when provider charge exceeds standard tariff (difference flagged)	High
ITEMS-TARIFF-TC-004	Verify unmapped service items flagged for manual review and tariff assignment	High
ITEMS-TARIFF-TC-005	Verify benefit coverage rules applied based on tariff code (covered/not covered/ partially covered)	High
ITEMS-TARIFF-TC-006	Verify claims processor can manually change tariff mapping with justification	Medium
ITEMS-TARIFF-TC-007	Verify tariff mapping exceptions logged for review and potential configuration updates	Medium

4.16 Ft Claims Attach Docs

4.16.1 Priority

Must Have

4.16.2 User Story

As a provider or claims processor, I want to upload and attach claim supporting documents so that medical justification is available for claims review and audit

4.16.3 Preconditions

Claim created or in submission process, documents scanned or available digitally in supported formats, file sizes within limits, internet connectivity available

4.16.4 Postconditions

Documents uploaded and attached to claim record, document types tagged appropriately, documents viewable in claim details, document upload audit logged

4.16.5 Test Cases

Id	Description	Weight
ATTACH-DOCS-TC-001	Verify PDF, JPG, and PNG files can be uploaded successfully	High
ATTACH-DOCS-TC-002	Verify file size limit of 10MB per file is enforced with clear error message	High
ATTACH-DOCS-TC-003	Verify multiple files can be attached to single claim (no limit on count)	High
ATTACH-DOCS-TC-004	Verify document type tagging (lab results, prescription, referral letter, discharge summary, X-ray)	High
ATTACH-DOCS-TC-005	Verify uploaded documents can be viewed/downloaded	High

Id	Description	Weight
	by claims processor during vetting	
ATTACH-DOCS-TC-006	Verify unsupported file formats rejected with list of supported formats	Medium
ATTACH-DOCS-TC-007	Verify document upload progress indicator displayed for large files	Low
ATTACH-DOCS-TC-008	Verify documents can be deleted/replaced before claim submission with confirmation prompt	Medium

4.17 Ft Claims Auto Adjudicate

4.17.1 Priority

Must Have

4.17.2 User Story

As the system, I want to automatically adjudicate claims against policy rules so that simple claims are processed instantly without manual review, reducing processing time

4.17.3 Preconditions

Claim submitted and passed validation, member policy active, adjudication rules configured, benefit limits and exclusions loaded, member eligibility confirmed

4.17.4 Postconditions

Claim automatically approved or flagged for manual review, benefit limits updated, admissible amount calculated, approval notification generated, claim moves to payment queue or vetting queue

4.17.5 Test Cases

Id	Description	Weight
AUTO-ADJUDICATE-TC-001	Verify claims within benefit limits and without exclusions are auto-approved	High
AUTO-ADJUDICATE-TC-002	Verify waiting period check auto-rejects claims for services still under waiting period	High
AUTO-ADJUDICATE-TC-003	Verify benefit limit check auto-rejects claims exceeding annual or per-visit limits	High
AUTO-ADJUDICATE-TC-004	Verify exclusion check auto-rejects claims for excluded services with rejection reason	High
AUTO-ADJUDICATE-TC-005	Verify gender-specific service validation auto-rejects inappropriate claims (maternity for males)	High
AUTO-ADJUDICATE-TC-006	Verify member inactive status triggers automatic rejection with clear reason	High
AUTO-ADJUDICATE-TC-007	Verify claims above threshold amount (e.g., $500) flagged for manual review regardless of rules	High
AUTO-ADJUDICATE-TC-008	Verify pre-authorization requirement check flags claims missing required pre-auth	High
AUTO-ADJUDICATE-TC-009	Verify auto-approved claims update member benefit utilization in real-time	High
AUTO-ADJUDICATE-TC-010	Verify auto-adjudication processing time is under 1 minute per claim	High

4.18 Ft Claims Vet Manual

4.18.1 Priority

Must Have

4.18.2 User Story

As a claims processor, I want to manually vet and review claims requiring human judgment so that I can make informed decisions on complex or high-value claims

4.18.3 Preconditions

Claim flagged for manual review, claim passed initial validation, claims processor logged in with vetting permissions, claim assigned to processor's queue

4.18.4 Postconditions

Claim approved, rejected, or queried with reasons documented, processor comments recorded, claim status updated, next workflow step triggered

4.18.5 Test Cases

Id	Description	Weight
VET-MANUAL-TC-001	Verify vetting dashboard displays all claims assigned to processor in priority order	High
VET-MANUAL-TC-002	Verify vetting screen displays complete member demographics, policy details, and benefit limits	High
VET-MANUAL-TC-003	Verify member's claim history for same diagnosis/provider displayed for comparison	High
VET-MANUAL-TC-004	Verify member's utilization summary (amount used vs. remaining limits) displayed	High

Id	Description	Weight
VET-MANUAL-TC-005	Verify attached supporting documents (lab results, prescriptions) can be viewed inline	High
VET-MANUAL-TC-006	Verify processor can approve claim with full or partial amount	High
VET-MANUAL-TC-007	Verify processor can reject claim with mandatory rejection reason selection	High
VET-MANUAL-TC-008	Verify processor can query claim back to provider for missing information	High
VET-MANUAL-TC-009	Verify special member notes (pre-existing conditions, fraud alerts) displayed prominently	High
VET-MANUAL-TC-010	Verify processor comments and decisions logged for audit trail with timestamp	High

4.19 Ft Claims Reject Reasons

4.19.1 Priority

Must Have

4.19.2 User Story

As a claims processor, I want to reject claims with coded rejection reasons so that providers receive clear, consistent feedback on why claims were denied

4.19.3 Preconditions

Claim being vetted, claim does not meet approval criteria, rejection reasons library configured, processor has rejection permissions

4.19.4 Postconditions

Claim status changed to rejected, rejection reason(s) recorded and visible, provider notified with rejection reasons, claim excluded from payment processing

4.19.5 Test Cases

Id	Description	Weight
REJECT-REASONS-TC-001	Verify standard rejection reason codes available for selection (benefit exhausted, waiting period, not covered, etc.)	High
REJECT-REASONS-TC-002	Verify multiple rejection reasons can be selected for single claim	High
REJECT-REASONS-TC-003	Verify free text notes field available for additional explanation	High
REJECT-REASONS-TC-004	Verify rejection reason mandatory before claim can be rejected	High
REJECT-REASONS-TC-005	Verify rejection notification sent to provider includes all rejection reasons and codes	High
REJECT-REASONS-TC-006	Verify rejected claims appear in provider transmittal with reasons clearly stated	High
REJECT-REASONS-TC-007	Verify rejection statistics tracked per reason code for reporting and process improvement	Medium

4.20 Ft Claims Partial Approve

4.20.1 Priority

Must Have

4.20.2 User Story

As a claims processor, I want to partially approve claims when some items are inadmissible so that I can pay for covered services while rejecting non-covered items

4.20.3 Preconditions

Claim contains multiple service items, some items covered and some not covered/excluded, processor reviewing claim with item-level details visible

4.20.4 Postconditions

Claim partially approved with admissible and inadmissible amounts separated, approved items processed for payment, rejected items flagged with reasons, provider notified

4.20.5 Test Cases

Id	Description	Weight
PARTIAL-APPROVE-TC-001	Verify processor can mark individual service items as approved or rejected	High
PARTIAL-APPROVE-TC-002	Verify approved amount auto-calculated as sum of approved items	High
PARTIAL-APPROVE-TC-003	Verify rejected items require reason selection (not covered, exceeds limit, not medically necessary, etc.)	High
PARTIAL-APPROVE-TC-004	Verify admissible amount processed through original policy benefit channel	High
PARTIAL-APPROVE-TC-005	Verify transmittal shows claimed amount, approved	High

Id	Description	Weight
	amount, rejected amount with item-level breakdown	
PARTIAL-APPROVE-TC-006	Verify member benefit utilization only updated for approved items	High
PARTIAL-APPROVE-TC-007	Verify processor can adjust approved amount per item (e.g., apply tariff pricing lower than provider charge)	High

4.21 Ft Claims Waiting Period

4.21.1 Priority

Must Have

4.21.2 User Story

As the system, I want to enforce waiting period restrictions during adjudication so that claims for services still under waiting period are automatically rejected per policy terms

4.21.3 Preconditions

Waiting periods configured per benefit type, member enrollment date recorded, claim service date captured, benefit waiting period mapping established

4.21.4 Postconditions

Claims within waiting period automatically rejected, waiting period end date calculated and displayed, rejection reason indicates waiting period, remaining days shown

4.21.5 Test Cases

Id	Description	Weight
WAITING-PERIOD-TC-001	Verify claims for services under waiting period are auto-	High

Id	Description	Weight
	rejected with specific waiting period reason	
WAITING-PERIOD-TC-002	Verify waiting period calculated from member entry date or policy start date per configuration	High
WAITING-PERIOD-TC-003	Verify waiting period end date displayed in member profile and vetting screen	High
WAITING-PERIOD-TC-004	Verify remaining days in waiting period displayed when claim rejected	High
WAITING-PERIOD-TC-005	Verify different waiting periods applied per benefit (e.g., 30 days maternity, 90 days dental)	High
WAITING-PERIOD-TC-006	Verify emergency services exempt from waiting period per policy configuration	High
WAITING-PERIOD-TC-007	Verify manager can override waiting period rejection with documented justification	Medium

4.22 Ft Claims Benefit Limits

4.22.1 Priority

Must Have

4.22.2 User Story

As the system, I want to check and enforce benefit limits (per visit, annual, lifetime) so that utilization is controlled according to policy terms and limits are not exceeded

4.22.3 Preconditions

Benefit limits configured per policy and benefit type, member utilization tracked in real-time, claim amount captured, limit types defined (per visit/day/year/lifetime)

4.22.4 Postconditions

Claim checked against applicable limits, claims exceeding limits rejected or flagged, utilization updated upon approval, remaining balance displayed, alternative settlement options considered

4.22.5 Test Cases

Id	Description	Weight
BENEFIT-LIMITS-TC-001	Verify per-visit limits enforced (claim amount cannot exceed configured per-visit limit)	High
BENEFIT-LIMITS-TC-002	Verify per-day limits enforced for inpatient claims (cost per day capped)	High
BENEFIT-LIMITS-TC-003	Verify annual benefit limits tracked and enforced across policy year	High
BENEFIT-LIMITS-TC-004	Verify lifetime limits tracked for specific benefits (e.g., orthodontics)	High
BENEFIT-LIMITS-TC-005	Verify remaining benefit balance displayed in real-time during vetting	High
BENEFIT-LIMITS-TC-006	Verify claims exceeding limits auto-rejected with specific limit exceeded reason	High
BENEFIT-LIMITS-TC-007	Verify exceeded amounts flagged for alternative settlement (SBP, Buffer, Indemnity)	High
BENEFIT-LIMITS-TC-008	Verify family-level limits enforced when configured	High

Id	Description	Weight
	(aggregate across all family members)	
BENEFIT-LIMITS-TC-009	Verify benefit balance resets on policy renewal date	High

4.23 Ft Claims Gender Validate

4.23.1 Priority

Must Have

4.23.2 User Story

As the system, I want to validate gender-specific services against member gender so that claims for biologically inappropriate services are automatically flagged or rejected

4.23.3 Preconditions

Member gender recorded in system, gender-specific services configured (maternity, prostate, gynecology, etc.), claim contains service codes, validation rules active

4.23.4 Postconditions

Gender-inappropriate claims auto-rejected with specific reason, override option available with manager approval, validation exception logged for audit

4.23.5 Test Cases

Id	Description	Weight
GENDER-VALIDATE-TC-001	Verify maternity services automatically rejected for male members with clear reason	High
GENDER-VALIDATE-TC-002	Verify prostate services automatically rejected for female members	High
GENDER-VALIDATE-TC-003		High

Id	Description	Weight
	Verify gynecological services automatically rejected for male members	
GENDER-VALIDATE-TC-004	Verify gender validation can be overridden by manager with documented justification (e.g., transgender members)	High
GENDER-VALIDATE-TC-005	Verify rejection notification clearly indicates gender validation failure reason	High
GENDER-VALIDATE-TC-006	Verify gender-specific service configuration can be maintained by admin users	Medium

4.24 Ft Claims Age Validate

4.24.1 Priority

Should Have

4.24.2 User Story

As the system, I want to validate age-appropriate services against member age so that unusual claims are flagged for review by claims processor

4.24.3 Preconditions

Member date of birth recorded, age calculated accurately, age-appropriate service ranges configured, claim contains service codes with age associations

4.24.4 Postconditions

Age-inappropriate claims flagged for review (not auto-rejected), flag visible in vetting screen, processor can approve with justification or reject

4.24.5 Test Cases

Id	Description	Weight
AGE-VALIDATE-TC-001	Verify pediatric services for members over 18 years flagged for review	Medium
AGE-VALIDATE-TC-002	Verify geriatric services for members under 65 years flagged for review	Medium
AGE-VALIDATE-TC-003	Verify immunization schedules validated against member age	Medium
AGE-VALIDATE-TC-004	Verify age validation flags are informational only, not automatic rejection	High
AGE-VALIDATE-TC-005	Verify processor can acknowledge age flag and proceed with approval or rejection	High
AGE-VALIDATE-TC-006	Verify age validation configuration can be updated by admin users	Medium

4.25 Ft Claims Sbp Process

4.25.1 Priority

Must Have

4.25.2 User Story

As a claims processor, I want to process rejected claims through Special Benefit Pool (SBP) so that I can provide coverage when standard benefit limits are exceeded

4.25.3 Preconditions

Claim rejected due to benefit limit exceeded, SBP configured for policy or benefit, SBP fund balance available, processor has SBP approval permissions

4.25.4 Postconditions

Claim processed through SBP channel, SBP balance deducted, approval workflow completed, provider notified, member SBP utilization tracked

4.25.5 Test Cases

Id	Description	Weight
SBP-PROCESS-TC-001	Verify claims exceeding benefit limits can be routed to SBP workflow	High
SBP-PROCESS-TC-002	Verify SBP balance displayed during processing with available and utilized amounts	High
SBP-PROCESS-TC-003	Verify claim amount deducted from SBP balance upon approval	High
SBP-PROCESS-TC-004	Verify SBP approval requires manager authorization per configured approval limits	High
SBP-PROCESS-TC-005	Verify SBP processing rejected if insufficient SBP balance available	High
SBP-PROCESS-TC-006	Verify SBP utilization tracked separately per policy or benefit as configured	High
SBP-PROCESS-TC-007	Verify payment voucher indicates SBP as settlement channel	Medium

4.26 Ft Claims Buffer Process

4.26.1 Priority

Must Have

4.26.2 User Story

As the system, I want to automatically process excess claims through Buffer/Excess of Loss cover so that high-cost claims exceeding policy limits are handled seamlessly

4.26.3 Preconditions

Claim exceeds configured buffer threshold, Buffer configured for policy or benefit, buffer balance available, member eligible for buffer

4.26.4 Postconditions

Claim automatically processed through buffer channel, buffer utilization tracked, reinsurance notification triggered if applicable, payment voucher generated

4.26.5 Test Cases

Id	Description	Weight
BUFFER-PROCESS-TC-001	Verify claims exceeding buffer threshold automatically routed to buffer processing	High
BUFFER-PROCESS-TC-002	Verify buffer balance checked before processing (available vs. utilized)	High
BUFFER-PROCESS-TC-003	Verify buffer utilization deducted from available buffer balance	High
BUFFER-PROCESS-TC-004	Verify buffer processing notification sent to reinsurance team for bordereaux reporting	High
BUFFER-PROCESS-TC-005	Verify payment voucher indicates buffer as settlement channel	Medium
BUFFER-PROCESS-TC-006	Verify buffer exhausted claims flagged for alternative settlement (indemnity, ex-gratia)	High
BUFFER-PROCESS-TC-007		Medium

Id	Description	Weight
	Verify buffer utilization reporting available per policy and per period	

4.27 Ft Claims Indemnity Process

4.27.1 Priority

Must Have

4.27.2 User Story

As a claims manager, I want to process claims through indemnity channel so that I can settle claims not covered by insurance but reimbursable by the client

4.27.3 Preconditions

Claim not covered under insurance policy, client has indemnity arrangement, client approval obtained, indemnity limits configured, manager has indemnity approval permissions

4.27.4 Postconditions

Claim processed through indemnity channel, invoice generated to client for reimbursement, provider paid, indemnity utilization tracked, approval workflow completed

4.27.5 Test Cases

Id	Description	Weight
INDEMNITY-PROCESS-TC-001	Verify rejected claims can be manually routed to indemnity processing by authorized users	High
INDEMNITY-PROCESS-TC-002	Verify client approval workflow triggered for indemnity claims	High
INDEMNITY-PROCESS-TC-003		High

Id	Description	Weight
	Verify indemnity claim generates separate invoice to client for reimbursement	
INDEMNITY-PROCESS-TC-004	Verify indemnity utilization tracked per client and per period	High
INDEMNITY-PROCESS-TC-005	Verify multiple approval levels enforced based on claim amount thresholds	High
INDEMNITY-PROCESS-TC-006	Verify payment voucher indicates indemnity as settlement channel	Medium
INDEMNITY-PROCESS-TC-007	Verify indemnity reporting available showing claims, approvals, and reimbursements	Medium

4.28 Ft Claims Exgratia Process

4.28.1 Priority

Must Have

4.28.2 User Story

As a senior manager, I want to process claims through ex-gratia (goodwill) channel so that I can settle exceptional cases for customer satisfaction and retention

4.28.3 Preconditions

Claim not covered under any standard channel, business justification documented, senior management approval required, ex-gratia limits configured per period

4.28.4 Postconditions

Claim processed through ex-gratia channel, business justification recorded, management approval documented, ex-gratia spending tracked against limits, provider paid

4.28.5 Test Cases

Id	Description	Weight
EXGRATIA-PROCESS-TC-001	Verify ex-gratia processing requires senior management approval (CFO/CEO level)	High
EXGRATIA-PROCESS-TC-002	Verify mandatory business justification field with detailed reason required	High
EXGRATIA-PROCESS-TC-003	Verify ex-gratia spending tracked against configured period limits (monthly/ annual)	High
EXGRATIA-PROCESS-TC-004	Verify ex-gratia claims exceeding period limit rejected with clear message	High
EXGRATIA-PROCESS-TC-005	Verify payment voucher indicates ex-gratia as settlement channel	Medium
EXGRATIA-PROCESS-TC-006	Verify ex-gratia approval audit trail maintained with approver name, date, and justification	High
EXGRATIA-PROCESS-TC-007	Verify ex-gratia reporting available for management review and analysis	Medium

4.29 Ft Claims Multi Channel

4.29.1 Priority

Should Have

4.29.2 User Story

As a claims processor, I want to process single claim through multiple settlement channels so that I can maximize coverage using all available options in sequence

4.29.3 Preconditions

Claim amount exceeds single channel capacity, multiple channels configured and available, processor understands channel sequencing rules, all necessary approvals obtainable

4.29.4 Postconditions

Claim split across multiple channels in configured sequence, each channel amount tracked separately, approval workflow completed for each channel, payment voucher shows channel breakdown

4.29.5 Test Cases

Id	Description	Weight
MULTI-CHANNEL-TC-001	Verify claim processing follows configured channel sequence (Policy → SBP → Buffer → Indemnity → Ex-gratia)	High
MULTI-CHANNEL-TC-002	Verify each channel's available balance checked before allocation	High
MULTI-CHANNEL-TC-003	Verify claim amount automatically split across channels up to each channel's limit	High
MULTI-CHANNEL-TC-004	Verify approval workflow triggered for each channel requiring approval (SBP, Indemnity, Ex-gratia)	High
MULTI-CHANNEL-TC-005	Verify payment voucher displays amount breakdown per channel	High
MULTI-CHANNEL-TC-006	Verify transmittal report shows channel breakdown to provider	Medium
MULTI-CHANNEL-TC-007	Verify multi-channel processing audit trail	Medium

Id	Description	Weight
	maintained for each channel segment	

4.30 Ft Claims Payment Voucher

4.30.1 Priority

Must Have

4.30.2 User Story

As a claims processor, I want to generate payment vouchers for approved claims so that I can authorize payment to providers through the finance system

4.30.3 Preconditions

Claims approved and ready for payment, claims grouped by provider, finance approval workflow available, Sage ERP integration configured, processor has payment voucher permissions

4.30.4 Postconditions

Payment voucher generated with unique number, multiple claims batched per provider, voucher includes claim details and amounts, voucher exported to Sage ERP for AP processing

4.30.5 Test Cases

Id	Description	Weight
PAYMENT-VOUCHER-TC-001	Verify payment voucher batches all approved claims for a provider in selected period	High
PAYMENT-VOUCHER-TC-002	Verify voucher displays provider name, tax ID, payment details, and bank account	High
PAYMENT-VOUCHER-TC-003	Verify voucher lists all claims with claim number, member	High

Id	Description	Weight
	name, service date, and approved amount	
PAYMENT-VOUCHER-TC-004	Verify voucher calculates total payable amount with any deductions (withholding tax, penalties)	High
PAYMENT-VOUCHER-TC-005	Verify voucher generates unique voucher number and integrates with Sage ERP AP module	High
PAYMENT-VOUCHER-TC-006	Verify voucher approval workflow triggered for amounts exceeding configured thresholds	High
PAYMENT-VOUCHER-TC-007	Verify voucher can be downloaded as PDF for printing and provider records	Medium
PAYMENT-VOUCHER-TC-008	Verify voucher status tracked (generated, approved, paid) with timestamps	High

4.31 Ft Claims Transmittal

4.31.1 Priority

Must Have

4.31.2 User Story

As a claims processor, I want to generate claims transmittal report so that I can communicate adjudication results to providers showing claimed vs payable amounts

4.31.3 Preconditions

Claims adjudicated (approved/rejected) for a provider, transmittal period selected, processor has transmittal generation permissions

4.31.4 Postconditions

Transmittal report generated showing summary and detailed views, total claimed vs total payable amounts calculated, rejected claims listed with reasons, report exportable to PDF/Excel

4.31.5 Test Cases

Id	Description	Weight
TRANSMITTAL-TC-001	Verify transmittal summary displays total claims count, total claimed amount, total payable amount, and total rejected amount	High
TRANSMITTAL-TC-002	Verify transmittal detail view lists each claim with claimed amount, payable amount, and status	High
TRANSMITTAL-TC-003	Verify rejected claims section lists all rejected claims with rejection reasons	High
TRANSMITTAL-TC-004	Verify partially approved claims show item-level breakdown with approved and rejected amounts	High
TRANSMITTAL-TC-005	Verify transmittal can be filtered by date range, claim status, and claim type	Medium
TRANSMITTAL-TC-006	Verify transmittal exportable to PDF for email to provider	High
TRANSMITTAL-TC-007	Verify transmittal exportable to Excel for provider's accounting systems	High
TRANSMITTAL-TC-008	Verify provider can access historical transmittals from provider portal	Medium

4.32 Ft Claims Notify Member

4.32.1 Priority

Should Have

4.32.2 User Story

As the system, I want to send SMS notification to member on claim utilization so that members are informed of their benefit usage and remaining balance

4.32.3 Preconditions

Claim approved, member has registered phone number, SMS gateway operational, notification settings enabled, member has not opted out

4.32.4 Postconditions

SMS sent to member within 15 minutes of approval, message includes service date, provider, amount utilized, remaining balance, SMS delivery logged

4.32.5 Test Cases

Id	Description	Weight
NOTIFY-MEMBER-TC-001	Verify SMS sent to member within 15 minutes of claim approval	High
NOTIFY-MEMBER-TC-002	Verify SMS includes service date, provider name, approved amount, and remaining benefit balance	High
NOTIFY-MEMBER-TC-003	Verify SMS delivery status logged (sent, delivered, failed)	Medium
NOTIFY-MEMBER-TC-004	Verify failed SMS delivery retried up to 3 times with exponential backoff	Medium
NOTIFY-MEMBER-TC-005		Medium

Id	Description	Weight
	Verify member can opt out of SMS notifications via member portal	
NOTIFY-MEMBER-TC-006	Verify notification not sent if member opted out of SMS communications	High
NOTIFY-MEMBER-TC-007	Verify SMS content follows configured template and character limits	Low

4.33 Ft Claims Provider Statement

4.33.1 Priority

Must Have

4.33.2 User Story

As a provider, I want to generate my account statement showing all transactions so that I have a comprehensive view of my account status with the insurance company

4.33.3 Preconditions

Provider logged into provider portal, transactions exist for provider (claims submitted, approved, rejected, paid), date range selected

4.33.4 Postconditions

Statement generated showing all transactions in chronological order, running balance calculated, as-at-date balance displayed, statement exportable to PDF/Excel

4.33.5 Test Cases

Id	Description	Weight
PROVIDER-STATEMENT-TC-001	Verify statement displays all claims submitted, approved,	High

Id	Description	Weight
	rejected, and paid within selected date range	
PROVIDER-STATEMENT-TC-002	Verify running balance calculated showing amounts billed, approved, and paid	High
PROVIDER-STATEMENT-TC-003	Verify as-at-date functionality shows balance as of any historical date	High
PROVIDER-STATEMENT-TC-004	Verify statement includes payment voucher numbers and payment dates for paid claims	High
PROVIDER-STATEMENT-TC-005	Verify statement exportable to PDF for printing	High
PROVIDER-STATEMENT-TC-006	Verify statement exportable to Excel for provider's accounting systems	High
PROVIDER-STATEMENT-TC-007	Verify statement aging analysis shows outstanding amounts by age buckets (0-30, 31-60, 61-90, 90+ days)	Medium

4.34 Ft Claims Reconcile Provider

4.34.1 Priority

Must Have

4.34.2 User Story

As a claims processor, I want to reconcile provider invoices against processed claims so that I ensure accurate payment and identify discrepancies

4.34.3 Preconditions

Provider submitted invoice with claim list, claims adjudicated in system, processor has reconciliation permissions, invoice acknowledgement generated

4.34.4 Postconditions

Invoice reconciled against claims in system, discrepancies identified and flagged, adjustment workflow initiated if needed, reconciliation report generated, payment voucher linked to invoice

4.34.5 Test Cases

Id	Description	Weight
RECONCILE-PROVIDER-TC-001	Verify reconciliation matches provider invoice line items to claims in system	High
RECONCILE-PROVIDER-TC-002	Verify discrepancies flagged when claimed amount on invoice differs from system records	High
RECONCILE-PROVIDER-TC-003	Verify missing claims (on invoice but not in system) flagged for investigation	High
RECONCILE-PROVIDER-TC-004	Verify extra claims (in system but not on invoice) flagged for provider clarification	High
RECONCILE-PROVIDER-TC-005	Verify adjustment workflow available to correct discrepancies	High
RECONCILE-PROVIDER-TC-006	Verify reconciliation report generated showing matched, unmatched, and discrepancy details	High
RECONCILE-PROVIDER-TC-007	Verify payment voucher can be linked to reconciled invoice for audit trail	Medium

4.35 Ft Claims Reverse Claim

4.35.1 Priority

Must Have

4.35.2 User Story

As a claims manager, I want to reverse claims and payment vouchers with proper controls so that I can correct errors and handle duplicate submissions

4.35.3 Preconditions

Claim processed (approved/paid), reversal reason identified, manager has reversal permissions, reversal controls configured, audit trail enabled

4.35.4 Postconditions

Claim reversed with status changed, member benefit balance credited back, reversal audit trail created with reason and approver, payment voucher reversed if already paid, provider notified

4.35.5 Test Cases

Id	Description	Weight
REVERSE-CLAIM-TC-001	Verify system checks if claim already paid before allowing reversal	High
REVERSE-CLAIM-TC-002	Verify reversal requires manager approval with documented reason	High
REVERSE-CLAIM-TC-003	Verify member's benefit balance credited back upon claim reversal	High
REVERSE-CLAIM-TC-004	Verify reversal audit trail created with timestamp, approver name, and reason	High
REVERSE-CLAIM-TC-005		High

Id	Description	Weight
	Verify alert generated if reversing claim that was already paid to provider	
REVERSE-CLAIM-TC-006	Verify payment voucher automatically reversed and recovery initiated if claim already paid	High
REVERSE-CLAIM-TC-007	Verify provider notified of claim reversal via email with reason	Medium
REVERSE-CLAIM-TC-008	Verify reversed claim status visible in all reports and queries	High

4.36 Ft Claims Duplicate Check

4.36.1 Priority

Must Have

4.36.2 User Story

As the system, I want to detect and prevent duplicate claim submissions so that we avoid paying twice for the same service

4.36.3 Preconditions

Claim being submitted or registered, duplicate detection rules configured (member + provider + service date + service type), historical claims database available

4.36.4 Postconditions

Duplicate claims flagged before processing, warning displayed to processor, override option available with justification, duplicate check logged for audit

4.36.5 Test Cases

Id	Description	Weight
DUPLICATE-CHECK-TC-001	Verify duplicate check runs on claim submission matching member + provider + service date + service type	High
DUPLICATE-CHECK-TC-002	Verify exact duplicate claim (same amount, same items) blocked with clear error message	High
DUPLICATE-CHECK-TC-003	Verify potential duplicate (same criteria but different amount) flagged for review	High
DUPLICATE-CHECK-TC-004	Verify duplicate warning displayed to claims processor during vetting	High
DUPLICATE-CHECK-TC-005	Verify processor can override duplicate check with documented justification (e.g., continuation of treatment)	High
DUPLICATE-CHECK-TC-006	Verify duplicate check audit trail maintained with override reasons	Medium
DUPLICATE-CHECK-TC-007	Verify duplicate check scope configurable (7 days, 30 days, 90 days lookback period)	Medium

4.37 Ft Claims Terminated Process

4.37.1 Priority

Must Have

4.37.2 User Story

As the system, I want to process claims for members terminated after service date so that I honor valid claims within grace period per policy terms

4.37.3 Preconditions

Claim submitted for member with terminated status, member's termination date available, service date captured on claim, grace period rules configured

4.37.4 Postconditions

Valid claims (service date before termination) processed normally, claims after termination auto-rejected with clear reason, grace period considered, warning displayed during vetting

4.37.5 Test Cases

Id	Description	Weight
TERMINATED-PROCESS-TC-001	Verify claims with service date before member termination date processed normally	High
TERMINATED-PROCESS-TC-002	Verify claims with service date after termination date auto-rejected with specific reason	High
TERMINATED-PROCESS-TC-003	Verify grace period considered (e.g., claims within 30 days of termination allowed per policy)	High
TERMINATED-PROCESS-TC-004	Verify warning message displayed during vetting when member is terminated	High
TERMINATED-PROCESS-TC-005	Verify member termination date and reason displayed in vetting screen	High
TERMINATED-PROCESS-TC-006	Verify manager can override termination rejection with documented justification	Medium
		Medium

Id	Description	Weight
TERMINATED-PROCESS-TC-007	Verify provider notified of member termination status to prevent future claims	

4.38 Ft Claims Register Report

4.38.1 Priority

Must Have

4.38.2 User Story

As a claims manager, I want to generate claims register report with comprehensive details so that I can track all claims and their status across the organization

4.38.3 Preconditions

Claims exist in system, manager has reporting permissions, report filters configured, date range selected

4.38.4 Postconditions

Claims register generated with all claim fields, filters applied successfully, report exportable to Excel, real-time data displayed

4.38.5 Test Cases

Id	Description	Weight
REGISTER-REPORT-TC-001	Verify report displays all claims with key fields (claim number, member, provider, amount, status)	High
REGISTER-REPORT-TC-002	Verify report filterable by date range (service date, submission date, approval date)	High
REGISTER-REPORT-TC-003		High

Id	Description	Weight
	Verify report filterable by provider, member, corporate client, and claim status	
REGISTER-REPORT-TC-004	Verify report filterable by claim type (IP/OP) and settlement channel	High
REGISTER-REPORT-TC-005	Verify report includes all claim detail fields (diagnosis, service items, amounts)	High
REGISTER-REPORT-TC-006	Verify report exportable to Excel with all columns and data preserved	High
REGISTER-REPORT-TC-007	Verify report displays real-time data reflecting current system state	High
REGISTER-REPORT-TC-008	Verify report pagination and sorting functionality for large datasets	Medium

4.39 Ft Claims Status Report

4.39.1 Priority

Must Have

4.39.2 User Story

As a claims manager, I want to view claims status dashboard showing pipeline so that I can monitor claims processing workflow and identify bottlenecks

4.39.3 Preconditions

Claims in various processing stages, manager has dashboard access, real-time data sync configured

4.39.4 Postconditions

Dashboard displays claims counts and values per stage, aging analysis shown, drill-down capability available, dashboard refreshes in real-time

4.39.5 Test Cases

Id	Description	Weight
STATUS-REPORT-TC-001	Verify dashboard displays claims count per stage (Submitted, Vetting, Approved, Rejected, Paid)	High
STATUS-REPORT-TC-002	Verify dashboard displays total claim value per stage	High
STATUS-REPORT-TC-003	Verify aging analysis shows claims by age brackets (0-7 days, 8-14 days, 15-30 days, 30+ days)	High
STATUS-REPORT-TC-004	Verify drill-down from dashboard summary to detailed claim list per stage	High
STATUS-REPORT-TC-005	Verify dashboard filterable by date range, provider, corporate client	High
STATUS-REPORT-TC-006	Verify dashboard data refreshes automatically (every 5 minutes) without page reload	Medium
STATUS-REPORT-TC-007	Verify visual indicators (charts, graphs) display claim flow and trends	Medium

4.40 Ft Claims Utilization Member

4.40.1 Priority

Must Have

4.40.2 User Story

As a claims manager or member, I want to generate member/family utilization report so that I can track benefit usage per member and family

4.40.3 Preconditions

Member has claims history, report parameters selected (member/family, date range), reporting permissions granted

4.40.4 Postconditions

Utilization report generated showing total claims, approved amounts, remaining limits by benefit type, claim ratio calculated, comparison to premium displayed

4.40.5 Test Cases

Id	Description	Weight
UTILIZATION-MEMBER-TC-001	Verify report displays total claims count and approved amounts for member	High
UTILIZATION-MEMBER-TC-002	Verify report shows utilization by benefit type (IP, OP, dental, optical, maternity)	High
UTILIZATION-MEMBER-TC-003	Verify report displays remaining benefit limits per benefit category	High
UTILIZATION-MEMBER-TC-004	Verify family utilization aggregated across all family members	High
UTILIZATION-MEMBER-TC-005	Verify claim ratio calculated (claims approved / premium paid)	High
UTILIZATION-MEMBER-TC-006	Verify report exportable to PDF for member distribution	Medium
UTILIZATION-MEMBER-TC-007	Verify member can access own utilization report from member portal	High

4.41 Ft Claims Utilization Corporate

4.41.1 Priority

Must Have

4.41.2 User Story

As an underwriter or account manager, I want to generate corporate utilization report with claim ratio so that I can analyze group performance for renewals and pricing

4.41.3 Preconditions

Corporate client has claims history, reporting period selected, underwriter has reporting permissions, premium data available

4.41.4 Postconditions

Corporate utilization report generated showing total claims, claim ratio, average claim costs (IP/OP), high claimants identified, trend analysis displayed

4.41.5 Test Cases

Id	Description	Weight
UTILIZATION-CORPORATE-TC-001	Verify report displays total claims count and approved amounts for corporate group	High
UTILIZATION-CORPORATE-TC-002	Verify claim ratio calculated (total claims / total premium) for reporting period	High
UTILIZATION-CORPORATE-TC-003	Verify average claim cost calculated separately for IP and OP claims	High
UTILIZATION-CORPORATE-TC-004	Verify high claimants identified (members with claims exceeding threshold, e.g., 3x average)	High
		High

Id	Description	Weight
UTILIZATION-CORPORATE-TC-005	Verify benefit utilization breakdown by benefit type showing usage patterns	
UTILIZATION-CORPORATE-TC-006	Verify trend analysis showing utilization change over multiple periods	High
UTILIZATION-CORPORATE-TC-007	Verify report exportable to Excel for renewal analysis and pricing models	High

4.42 Ft Claims Exception Report

4.42.1 Priority

Must Have

4.42.2 User Story

As a claims manager or fraud investigator, I want to generate exception reports flagging unusual patterns so that I can detect potential fraud and abuse

4.42.3 Preconditions

Exception rules configured with thresholds, claims data available for analysis, manager has fraud investigation permissions

4.42.4 Postconditions

Exception report generated with flagged claims, unusual patterns highlighted, configurable alert thresholds, drill-down to claim details available

4.42.5 Test Cases

Id	Description	Weight
EXCEPTION-REPORT-TC-001	Verify high claim amounts exceeding configured threshold flagged for review	High

Id	Description	Weight
EXCEPTION-REPORT-TC-002	Verify frequent visits by same member to same provider flagged (e.g., >10 visits per month)	High
EXCEPTION-REPORT-TC-003	Verify unusual diagnoses or diagnosis-procedure mismatches flagged	High
EXCEPTION-REPORT-TC-004	Verify after-hours claims (submitted outside normal business hours) flagged	Medium
EXCEPTION-REPORT-TC-005	Verify excessive repeat procedures for same member flagged	High
EXCEPTION-REPORT-TC-006	Verify exception thresholds configurable by admin users	High
EXCEPTION-REPORT-TC-007	Verify drill-down from exception summary to detailed claim records	High
EXCEPTION-REPORT-TC-008	Verify exception report exportable for fraud investigation case files	Medium

4.43 Ft Claims Provider Performance

4.43.1 Priority

Should Have

4.43.2 User Story

As a provider network manager, I want to analyze claims experience per provider so that I can identify high-cost providers and network optimization opportunities

4.43.3 Preconditions

Provider claims history available, reporting period selected, network manager has reporting permissions, benchmarks configured

4.43.4 Postconditions

Provider performance report generated showing total claims, average cost, rejection rate, turnaround time, provider ranking, cost comparison to network average

4.43.5 Test Cases

Id	Description	Weight
PROVIDER-PERFORMANCE-TC-001	Verify report displays total claims count and value per provider	High
PROVIDER-PERFORMANCE-TC-002	Verify average claim cost calculated per provider and compared to network average	High
PROVIDER-PERFORMANCE-TC-003	Verify rejection rate calculated (rejected claims / total claims) per provider	High
PROVIDER-PERFORMANCE-TC-004	Verify average turnaround time calculated (submission to approval) per provider	High
PROVIDER-PERFORMANCE-TC-005	Verify provider ranking by cost, utilization, and quality metrics	High
PROVIDER-PERFORMANCE-TC-006	Verify cost comparison showing providers above/ below network benchmarks	High
PROVIDER-PERFORMANCE-TC-007	Verify report exportable for provider contract negotiations	Medium

4.44 Ft Claims Age Region Analysis

4.44.1 Priority

Should Have

4.44.2 User Story

As an actuarial analyst, I want to analyze claim experience by age band and region so that I support actuarial pricing and risk assessment

4.44.3 Preconditions

Claims data available with member demographics, age bands configured, regions defined, actuarial analyst has reporting permissions

4.44.4 Postconditions

Age/region analysis report generated showing claim frequency and severity by segment, trends identified, exportable for actuarial models

4.44.5 Test Cases

Id	Description	Weight
AGE-REGION-ANALYSIS-TC-001	Verify claims segmented by age bands (0-18, 19-35, 36-50, 51-65, 65+)	High
AGE-REGION-ANALYSIS-TC-002	Verify claims segmented by region (Dar es Salaam, Arusha, Mwanza, etc.)	High
AGE-REGION-ANALYSIS-TC-003	Verify claim frequency calculated (claims per 1000 members) by segment	High
AGE-REGION-ANALYSIS-TC-004	Verify claim severity calculated (average claim cost) by segment	High
AGE-REGION-ANALYSIS-TC-005		Medium

Id	Description	Weight
	Verify gender analysis overlayed with age/region segmentation	
AGE-REGION-ANALYSIS-TC-006	Verify report exportable to Excel for actuarial pricing models	High
AGE-REGION-ANALYSIS-TC-007	Verify trend analysis showing changes across multiple policy periods	Medium

4.45 Ft Claims Exceeded Benefits

4.45.1 Priority

Must Have

4.45.2 User Story

As a finance manager, I want to generate report on exceeded benefits requiring alternative settlement so that I can track usage of SBP, Buffer, Indemnity, and Ex-gratia channels

4.45.3 Preconditions

Claims processed through alternative settlement channels, reporting period selected, finance manager has reporting permissions

4.45.4 Postconditions

Exceeded benefits report generated showing amounts per channel (SBP, Buffer, Indemnity, Ex-gratia), breakdown per client/member/benefit, approval tracking included

4.45.5 Test Cases

Id	Description	Weight
EXCEEDED-BENEFITS-TC-001	Verify report displays total amounts processed through	High

Id	Description	Weight
	each alternative settlement channel	
EXCEEDED-BENEFITS-TC-002	Verify SBP utilization tracked per client and compared to SBP limits	High
EXCEEDED-BENEFITS-TC-003	Verify Buffer utilization tracked and compared to buffer limits	High
EXCEEDED-BENEFITS-TC-004	Verify Indemnity claims listed with client approval status and reimbursement tracking	High
EXCEEDED-BENEFITS-TC-005	Verify Ex-gratia spending tracked against period limits with justifications	High
EXCEEDED-BENEFITS-TC-006	Verify report breakdown by benefit type showing which benefits frequently exceed limits	High
EXCEEDED-BENEFITS-TC-007	Verify report exportable for finance and management review	Medium